

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

CERTIFICATE OF DEATH

08411

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County WicomicoCity or town Mardela
(If outside city or town limits, write RURAL and give nearest town)Street No. R.D.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Adkins Mr. Russell Taylor

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife White, mrs. Nina

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age 54 years

8. AGE:

Years

Months

Days

If less than one day

5003hrs.min.

9. Birthplace

Wicomico County Md.
(Town, county, and state)

10. Usual occupation

Farmen

11. Industry or business

FATHER

12. Name

David Henry Adkins

13. Birthplace

Pomellville Md.

MOTHER

14. Maiden name

Sarah Margaret Taylor

15. Birthplace

R.D. Quantico Md.

16. Informant

Mrs. Nina B. Adkins

Address

R.D. Mardela Md.

17. Burial

(Burial, cremation, or removal)

Which?

Date thereof

Aug. 19-1946
(month) (day) (year)

Cemetery or crematory

Mardela Cem.

Location

Mardela Maryland

18. Funeral director

William G. Miller R. Miller

Address

Salisbury Md.

19.

(Date rec'd by registrar)

8/19/46

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 19 46 at 7 A. M

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

July 28 19 46 to August 17 19 46and that I last saw him alive on August 17 19 46Immediate cause of death Nephrosclerosis DURATIONwith renal failure 6 monthsExuremia SymptomsDue to Chronic (essential) Symptomshypertension 3 years

Due to

Other conditions Hypertensive HeartDissecting Aneurysm "colitis"

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Removal into bowel structure &

PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:

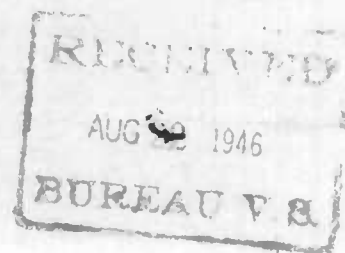
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David J. Gilmore M.D. M. D. or otherAddress 301 N. Division St. Date signed 8/17/46Salisbury, Md.



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08412

Reg. Dist. No. 330

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

19. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 3, 1946, at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 1st 1946, to Aug 3rd 1946, and that I last saw him alive on Aug 3rd 1946

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED

AUG 10 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08413

Reg. Dist. No. 331

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH: County... <u>Stromio</u> City or town... <u>Mardela Md R.D.</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?... <u>5 years</u> Hospital, institution, or street address where death occurred: _____ How long in hospital or institution?..... | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State... <u>Md</u> County... <u>Chic</u> City or town... <u>Mardela Md R.D.</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war..... | | | |
| 3. (a) FULL NAME <u>Mary E. Bradley</u> | | | | 3. (b) Social Security Number _____ | | | |
| 4. Sex <u>F</u> | | 5. Color or race <u>White</u> | | 6. (c) Single, married, widowed, or divorced <u>Widow</u> | | | |
| 6. (b) Name of husband or wife <u>William F. Bradley</u> | | | | 6. (c) If alive, give age years | | | |
| 7. Birth date of deceased (mo., day, yr.) <u>June 2 1862</u> | | | | 8. AGE: Years <u>84</u> Months <u>1</u> Days <u>3</u> It less than one day hrs. min. | | | |
| 9. Birthplace <u>Riverton Chic Md</u> (Town, county, and state) | | | | | | | |
| 10. Usual occupation <u>House work</u> | | | | | | | |
| 11. Industry or business <u>Joseph Taylor</u> | | | | | | | |
| 12. Name <u>1 Md.</u> | | | | | | | |
| 13. Birthplace <u>Elizabeth Bennett</u> | | | | | | | |
| 14. Maiden name <u>Md</u> | | | | | | | |
| 15. Birthplace <u>Md</u> | | | | | | | |
| 16. Informant <u>Mrs Mack Beckerson</u> Address <u>Mardela Md R.D.</u> | | | | | | | |
| 17. Burial Date thereof <u>8 20 1946</u> (Burial, cremation, or removal, which?) (month) (day) (year) Cemetery or crematory... <u>Riverton</u> Location... <u>Riverton Md</u> <u>Gravener Bros</u> Address <u>Sharptown Md</u> | | | | | | | |
| 18. Funeral director <u>8/20/46</u> 19 <u>W.H. Robertson</u> (Date rec'd by registrar) Registrar | | | | | | | |
| MEDICAL CERTIFICATION 20. DATE OF DEATH <u>Aug 18</u> 19 <u>46</u> , at <u>2809</u> M 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Jan 1946</u> to <u>Aug 18</u> 19 <u>46</u> and that I last saw him alive on <u>Aug 17</u> 19 <u>46</u> Immediate cause of death <u>Carcinoma Breast</u> DURATION <u>6.75 yrs</u> Due to..... Due to..... Other conditions <u>Cerebral Hemorrhage</u> <u>9 months</u> (include pregnancy within 3 months of death) Major findings of operations..... Date of op..... Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically. | | | | | | | |
| 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?..... | | | | | | | |
| 23. SIGNATURE <u>W.S. Nicholson M.D.</u> M. D. or other Address <u>Sharptown Md</u> Date signed <u>8/19/46</u> | | | | | | | |

RECEIVED
AUG 23 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74a

CERTIFICATE OF DEATH

08414

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
 City or town Pittsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 84 yrs
 Hospital, institution, or street address where death occurred
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Wicomico
 City or town Pittsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. no street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Joanne Moriah Brittingham

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife 8. (c) If alive, give age years

Lorenz Brittingham

7. Birth date of deceased (mo., day, yr.) Dec 21, 1860

8. AGE: Years 84 Months 7 Days 28 It less than one day hrs. min.

9. Birthplace Pittsville (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

12. Name Josephus H. Melson

13. Birthplace Md.

14. Maiden name Julia Forlow

15. Birthplace Md.

16. Informant Mrs. Paul Baker

Address Berlin, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 21, 1946

(month) (day) (year)

Cemetery or crematory Forlows Cemetery

Location Pittsville, Md.

18. Funeral director M. Pasha Watson

Address Selkville, Del.

19. 8/21/46 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19 1946 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1946 to day of death, and that I last saw her alive on Aug 19, 1946

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other conditions Hypertension

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE J. H. Lewis M.D.

Address M. D. or other

Date signed 8-28-46

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

A HUMAN BEING'S DEATH

PLACE HERE

POSTAL TELEGRAPH

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AUG 24 1946

BUREAU

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 393

1. PLACE OF DEATH

County McComick
 City or town Pocomoke
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution or street address where death occurred:
R.O.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State Md County McComick
 City or town Pocomoke
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.O.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Isaac S. Brown

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Sept 9 1871

6.(c) If alive, give age years

8. AGE:

Years 74 Months 11 Days 14
 If less than one day
hrs. min.

9. Birthplace

R.O. Pocomoke Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

Farmer

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

17. Address

18. Burial

19. Date thereof

20. Cemetery or crematory

21. Location

22. Burial director

23. Address

24. Date signed

25. Registrar

26. Date signed

27. Address

28. Date signed

29. Address

30. Date signed

31. Address

32. Date signed

33. Address

34. Date signed

35. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 23 1946 at unborn M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1946 to unborn
 and that I last saw h. unborn on unborn 1946

Immediate cause of death

coronary occlusion

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Isaac S. Brown
 Address Pocomoke Md Date signed 8/26/46

STANDARD TIME

STANDARD TIME

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AUG 29 1946

BUREAU

Permanently

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 08413 337

1. PLACE OF DEATH:

County Wicomico
 City or town White Haven
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 56 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Wicomico
 City or town White Haven
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Sarah Wainwright Dashiell

3. (b) Social Security Number

4. Sex Female 5. Color or race Col 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife George E Dashiell
 6. (c) If alive, give age 64 years
 7. Birth date of deceased (mo., day, yr.) June 18-1890
 8. AGE: Years 56 Months 1 Days 26 If less than one day
 hrs. min.

9. Birthplace White Haven Md.
 (Town, county, and state)
 10. Usual occupation Teaching
 11. Industry or business

MOTHER FATHER
 12. Name Samuel Wainwright
 13. Birthplace White Haven Wicomico
 14. Maiden name Hester Conway
 15. Birthplace White Haven Wicomico

16. Informant George E Dashiell
 Address White Haven Md R. 7 Box 8

17. Burial Date thereof Aug 19, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory White Haven
 Location White Haven Md
Chas H Ward

18. Funeral director Marion Md.
 Address

19. Aug 16 19 46 R. W. Wilford Walter
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 19 46 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22 19 46 to Aug 14 19 46

and that I last saw him alive on August 12 19 46

Immediate cause of death Cardiac Failure

DURATION

Due to

Due to Chronic Nephritis, interstitial

Duration: Questionable

Other conditions Cong. R.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert J. Gore M. D. or other

Address Northcote Md. Date signed 8-16-46

RL

AUG 23 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 38

08417

FILM No. I 08 OCT 28 1946

CERTIFICATE OF DEATH

★ Reg. Dist. No. 337

1. PLACE OF DEATH:

County Wicomico

City or town Nanticoke
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Wicomico

City or town Nanticoke
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary Caroline Douglas

3. (b) Social Security Number

4. Sex

7

5. Color or race

white

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Lafayette Douglas

7. Birth date of

deceased (mo., day, yr.)

Oct. 8, 1864

6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

if less than one day

82 81

10

19

hrs.

min.

9. Birthplace

Nanticoke, Wicomico, Md.
(Town, county, and state)

10. Usual occupation

House work

11. Industry or business

FATHER
MOTHER

12. Name

Edward Travers

13. Birthplace

Nanticoke, Md.

14. Maiden name

Margaret Messick

15. Birthplace

Nanticoke, Md.

16. Informant

Stella Willing

Address

Nanticoke, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

8/29/46
(month) (day) (year)

Cemetery or crematory

Cemetery (Turners)

Location

Nanticoke, Md.

18. Funeral director

P. G. Messick

Address

Buwalve, Md.

19.

(Date rec'd by registrar)

19. 46

Registrar

P. Walcott Walker

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 19. 46 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 26 19. 46 to _____ 19. _____

and that I last saw him/her alive on August 26 19. 46

Immediate cause of death

Generalized Carcinomatosis

DURATION

7

Due to

Carcinoma of breast

4 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Robert J. Gore MD

M. D. or other

Address Nanticoke, Md. Date signed 8-27-46

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SEP 5 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1912

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County.....Wicomico
 City or town.....Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....55 Years
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution?.....15 Min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md County.....Wicomico
 City or town.....Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....125 W. Locust St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3.(a) FULL NAME

William S. Dykes

3.(b) Social Security Number

4. Sex.....male 5. Color or race.....white 6.(a) Single, married, widowed, or divorced.....married
 6.(b) Name of husband or wife.....Susie L. Dykes
 6.(c) If alive, give age.....51 years
 7. Birth date of deceased (mo., day, yr.).....May 17, 1891
 8. AGE: Years.....55 Months.....2 Days.....23 If less than one day..... hrs. min.

9. Birthplace.....Salisbury, Wicomico, Co. Md
 (Town, county, and state)
 10. Usual occupation.....Salesman
 11. Industry or business.....Wholesale Groceries
 12. Name.....Stansbury W. Dykes
 13. Birthplace.....Wicomico, Co. Md
 14. Maiden name.....Elvina Brown
 15. Birthplace.....Wicomico, Co. Md

16. Informant.....Richard W. Dykes
 Address.....Salisbury, Md
 17. Burial.....Aug. 12, 1946
 (Burial, cremation, or removal, Which?)..... (month) (day) (year)
 Cemetery or crematory.....Parsons Cemetery
 Location.....Salisbury, Md
 18. Funeral director.....The Hill & Johnson Co.
 Address.....Salisbury, Md

19. 8/15 1946 Registrar
 (Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Aug. 9, 1946 19.....1115 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1938 to Aug 9 1946
 and that I last saw him alive on Aug - 8 1946

Immediate cause of death.....Coronary Thrombosis after 12
 DURATION

Due to.....

Due to.....

Other conditions.....Hypertension
Chronic nephritis } 10 to 12
 (Include pregnancy within 3 months of death) } years

Major findings of operations.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....Arthur R. Mann M. D. or other
 Address.....Salisbury, Md Date signed 8/12/46

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AUG 20 1946

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

08419

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH

County McComieCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

413. Sans St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County McComieCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 413. Sans St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Edwin Shays Fitch

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 1946 at 4:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 15 1946 to August 14 1946and that I last saw him alive on August 14 1946

Immediate cause of death

Respiratory Failure

DURATION

1 day

Due to

Progressive Bulbar
Palsy

2

Due to

Other conditions (Frederick Syndrome)

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE.....

M. D. or other

Address Salisbury, Md. Date signed 8/23/46

6. (b) Name of husband or wife

Amanda Sarah Fitch

7. Birth date of

deceased (mo., day, yr.)

June 3 18936. (c) If alive, give age 48 years

8. AGE:

Years

Months

Days

If less than one day

53213

.....hrs.min.

9. Birthplace

Philadelphia Pa
(Town, county, and state)

10. Usual occupation

murder suspect

11. Industry or business

No Record

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

18. Funeral director

19. Date rec'd by registrar

20. Date of death

21. Date of burial

22. Date of cremation

23. Date of interment

24. Date of exhumation

25. Date of reinterment

26. Date of removal

27. Date of reinterment

28. Date of removal

29. Date of reinterment

30. Date of removal

31. Date of reinterment

32. Date of removal

33. Date of reinterment

34. Date of removal

35. Date of reinterment

36. Date of removal

37. Date of reinterment

38. Date of removal

39. Date of reinterment

40. Date of removal

41. Date of reinterment

42. Date of removal

43. Date of reinterment

44. Date of removal

45. Date of reinterment

46. Date of removal

47. Date of reinterment

48. Date of removal

49. Date of reinterment

50. Date of removal

51. Date of reinterment

52. Date of removal

53. Date of reinterment

54. Date of removal

55. Date of reinterment

56. Date of removal

57. Date of reinterment

58. Date of removal

59. Date of reinterment

60. Date of removal

61. Date of reinterment

62. Date of removal

63. Date of reinterment

64. Date of removal

65. Date of reinterment

66. Date of removal

67. Date of reinterment

68. Date of removal

69. Date of reinterment

70. Date of removal

71. Date of reinterment

72. Date of removal

73. Date of reinterment

74. Date of removal

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76. Date of removal

77. Date of reinterment

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80. Date of removal

81. Date of reinterment

82. Date of removal

83. Date of reinterment

84. Date of removal

85. Date of reinterment

86. Date of removal

87. Date of reinterment

88. Date of removal

89. Date of reinterment

90. Date of removal

91. Date of reinterment

92. Date of removal

93. Date of reinterment

94. Date of removal

95. Date of reinterment

96. Date of removal

97. Date of reinterment

98. Date of removal

99. Date of reinterment

100. Date of removal

RECEIVED

AUG 26 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12216

08420

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:

P. G. HospitalHow long in hospital or institution? 5 days

3. (a) FULL NAME

Rosa Bell Gaddy

4. Sex

F

5. Color or race

col

6. (a) Single, married, widowed, or divorced

Single

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 4, 1916

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

30419

hrs. min.

9. Birthplace Wadesboro, N. C.

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name George Gaddy13. Birthplace Wadesboro, N. C.14. Maiden name Lonie Biles15. Birthplace Wadesboro, N. C.16. Informant George GaddyAddress 1227 Gholston St. WinstonSalem, N. C.17. Burial (Burial, cremation, or removal. Which?) BurialDate thereof 8/27/46

(month) (day) (year)

Cemetary or crematory Evergreen Cem.Location Winston Salem, N. C.18. Funeral director E. G. MessickAddress Bryalve, Md.19. 8/27/46 Registrar(Date rec'd by registrar) 19 46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County WicomicoCity or town Salisbury, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1946 at 12:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 18, 46 to Aug 23, 46and that I last saw her alive on Aug 22, 46

Immediate cause of death

Intestinal obstruction

DURATION

3 daysDue to Abdominal adhesions2 mo.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations hangover of intestineadhesions, 2 obstructions Date of op. 8/23/46

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. R. Rademaker

M. D. or other

Address Salisbury, Md.Date signed 8/27/46

RECEIVED

AUG 28 1946

BUREAU V A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

08421

Reg. Dist. No. 333

1. PLACE OF DEATH:

County... Wicomico
 City or town... Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? One day - 11 hrs. 44 mins
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution? One day - 11 hrs. 44 mins

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
MD County Dorchester
 State...
 City or town... Wicoma
 (If outside city or town limits, write RURAL and give nearest town)
 Street No...
 (If rural, give LOCATION)
 2.(a) If veteran, name war... ☒

3. (a) FULL NAME

Gibbons Baby Boy (Twin 1)

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male white

6. (b) Name of husband or wife

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) Aug. 16 - 1946

8. AGE: Years Months Days If less than one day
0 0 0 0 hrs. min.

9. Birthplace P.B. Hopt. Salisbury Md
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Marvin C. Gibbons

13. Birthplace Princeton Anne Md

14. Maiden name Alice Dryden

15. Birthplace Princeton Anne Md

16. Informant Mr. Marvin C. Gibbons

Address Wicoma Maryland

17. Burial Date thereof Aug. 19 - 1946
 (Burial, cremation, or removals Which?) (month) (day) (year)

Cemetery or crematory Waco Mem Park

Location Salisbury Md

18. Funeral director Walter R. Johnson

Address Salisbury Maryland

19. 8/19/46 Registrar Robert R. Starr
 (Date recd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 19 46, at 10:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 16 19 46 to Aug. 17 19 46

and that I last saw him alive on August 17 19 46

Immediate cause of death Respiratory failure DURATION

Due to Prematurity

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert R. Starr

M. D. or other

Address Salisbury Date signed 8-18-46

RECEIVED

AUG 22 1945

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County..... WicomicoCity or town..... Salisbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... 5 years

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution?..... 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... WicomicoCity or town..... Powellville
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

William J. Goodwin

3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

malewhite

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) not available8. AGE: Years Months Days If less than one day
51..... hrs. min.9. Birthplace..... not available
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name..... not available

13. Birthplace.....

14. Maiden name..... not available

15. Birthplace.....

16. Informant.....

Address.....

17. Burial Date thereof AUG 19, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Parsons CemeteryLocation..... Salisbury, Md18. Funeral director..... The Hill & Johnson Co.Address..... Salisbury, Md19. 8/36 (Date read by registrar)19. 4619. Barrie E. Johnson19. Salisbury, Md19. Registrar19. Address19. Date signed

MEDICAL CERTIFICATION

20. DATE OF DEATH..... AUG. 10, 1946 19..... LI 48A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19.....
and that I last saw him..... 19.....

Immediate cause of death.....

Fractured Skull - Brain Injury

DURATION

7 days

Due to.....

Due to.....

Other conditions..... none

(Include pregnancy within 8 months of death)

Major findings of operations..... none

Date of op.....

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... accident Date of..... 8-3-46Where did injury occur?..... near Salisbury, Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?)..... highwayMeans of injury..... Fell off Truck Injured at work?..... No23. SIGNATURE..... Barrie E. Johnson
M. D. or other.....Address..... Salisbury, Md Date signed..... 8/13/46

RECEIVED
AUG 28 1946
BUREAU 7 F

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

CERTIFICATE OF DEATH

Reg. Dist. No. 330

1. PLACE OF DEATH:

County... *Wicomico*City or town... *Mardela*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *Md* County... *Wicomico*City or town... *Mardela*
(If outside city or town limits, write RURAL and give nearest town)Street No. *Bridge street*
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

4. Sex *Male* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced *Married*

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age *27* years

8. AGE:

Years

Months

Days

If less than one day

*36**1**12*

hrs.

min.

9. Birthplace

Brooklyn, New York
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal) Which?

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

W. Robertson
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 6th 1946 at *330 E. M*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on *Aug 6* 1946

Immediate cause of death

Acute Cardiac

DURATION

Due to

Myocardial Infarction

Due to

Diabetes

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed *Aug 7/46*

MARGIN RESERVED FOR BINDING

VS A15

9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 10 1946

BUREAU 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 128

CERTIFICATE OF DEATH

Reg. Dist. No. 333

08424

1. PLACE OF DEATH:

County Wilcomica
 City or town Salisbury and
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Unknown
 Hospital, institution, or street address where death occurred: na
 How long in hospital or institution? na

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Wilcomica
 City or town Salisbury and
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. na
 (If rural, give LOCATION)
 2(a) If veteran, name war Don't know

3. (a) FULL NAME

James Griffin

3. (b) Social Security Number

Don't know

4. Sex

male

5. Color or race

a.a. unknown

6. (a) Single, married, widowed, or divorced

unknown

6. (b) Name of husband or wife

unknown

7. Birth date of deceased (mo., day, yr.)

about 1906

8. AGE:

about 40

9. Birthplace

unknown

10. Usual occupation

Don't know

11. Industry or business

Same as above

12. Name

unknown

13. Birthplace

unknown

14. Maiden name

unknown

15. Birthplace

unknown

16. Informant

none

17. Address

none

18. Burial

Public

19. Location

Salisbury and

20. Funeral director

James P. Stewart

21. Address

Salisbury and

22. Date signed by Registrar

8/19/46

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 1946 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on 24 August 1946

Immediate cause of death

Drowning

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

RECEIVED

AUG 22 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 08425 393

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Permanently General HospitalHow long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Wisconsin County AcworthCity or town Hallwood
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Haley Mrs. Sadie

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced6. (b) Name of husband or wife Haley Mr. Herbert J.7. Birth date of deceased (mo., day, yr.) February 8th, 1885 8. (c) If alive, give age _____ years8. AGE: Years 61 Months _____ Day _____ If less than one day _____ hrs. _____ min.9. Birthplace Hallwood
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name William J. Hankford13. Birthplace near Hallwood, Va.14. Maiden name Willie Anna Leader15. Birthplace Hallwood, Va.16. Informant Herbert J. HaleyAddress Hallwood, Va.17. Burial Date thereof Aug. 7, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory GreenwoodLocation Temperanceville, Va.18. Funeral director J. D. Johnson Inc.Address Parkersburg, Va.19. 8/7/46 19. 46 Harris J. D. Johnson
(Date rec'd by registrar) (month) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5 1946 at 109 M

21. I CERTIFY that death occurred on the day above stated; that I attended deceased from

July 30 1946 to Aug 5 1946and that I last saw him/her alive on Aug 5 1946Immediate cause of death Circumstances of death DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op. 1/1/46

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ✓ Date of _____Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ injured at work?

23. SIGNATURE J. B. Vick M. D. or otherAddress Hallwood, Va. Date signed 8/5/46

RECEIVED
AUG 10 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 158

CERTIFICATE OF DEATH

Reg. Dist. No. 08426 388

1. PLACE OF DEATH:

County Wicomico
 City or town Eden P.O.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Birth
 Hospital, institution, or street address where death occurred: no
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Wicomico
 City or town Eden P.O.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Charlie James Harris

3. (b) Social Security Number

4. Sex Male 5. Color or race colored 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Aug. 30, 1946
 8. AGE: Years _____ Months _____ Days _____ It less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1946, at ? M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____
 and that I last saw him/her alive on Aug 29 19____
 Immediate cause of death new born
 DURATION 1/2 hr
 Due to _____
 Due to _____
 Other conditions _____

9. Birthplace Wicomico co. md
 (Town, county, and state)
 10. Usual occupation none
 11. Industry or business _____

12. Name John Harris
 13. Birthplace Georgia
 14. Maiden name Maude Harris Brown
 15. Birthplace Georgia

16. Informant John Harris
 Address Eden, Md. P.O. 2

17. Burial Date thereof Sept 2 - 46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Penstock Farm
 Location Silomar, Md

18. Funeral director The Hill & Johnson
 Address Salisbury

19. 9/1/46 1946 Charles E. Johnson
 (Date rec'd by registrar) (month) (day) (year) Registrar

(Include pregnancy within 3 months of death)
 Major findings of operations None
 Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE SA Kademacher M.P.
 Address Salisbury Md M. D. or other _____
 Date signed 9/2/46

RECEIVED

SEP 26 1946

BUREAU V E

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 562

CERTIFICATE OF DEATH

Reg. Dist. No. 08427 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

3. (a) FULL NAME

Addie Holbrook

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Harry Holbrook

7. Birth date of deceased (mo., day, yr.) June 16, 1906 6. (c) If alive, give age 45 years

8. AGE: Years 40 Months 1 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Wicomico County, Maryland
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business None

12. Name Bayard H. Quinton

13. Birthplace Wicomico County, Maryland

14. Maiden name Ardella A. Goslee

15. Birthplace Wicomico County, Maryland

16. Informant Harry Holbrook

Address Mardela Springs, Maryland, RFD.

17. Burial Date thereof August 15, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory San Domingo Cemetery

Location Near Sharptown, Maryland

18. Funeral director J. J. Trampton and Son

Address Federalburg, Maryland

19. 8/16/46 Registrar Harriet E. Johnson

(Date recd by registrar) 19 46 Registrar Seal

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Mardela Springs - Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. San Domingo
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 19 46 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 11 19 46 to Aug 11 19 46 and that I last saw him or alive on Aug 11 19 46

Immediate cause of death Neumonia, Viral DURATION 3 days

Due to Infection 10 days

Due to Previous operation for Fibroid tumor of uterus

Other conditions Thrombosis of uterine arteries & Venae cavae

Major findings of operations Fibroid tumor

acute salpingitis Date of op. 7/26/46

Autopsy results Pl. pulm. embolism & as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE L. R. Rademacher M. D. or other _____

Address Salisbury, Md Date signed 8/11/46

MARGIN RESERVED FOR BINDING

VS A15 9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 20 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

CERTIFICATE OF DEATH

Reg. Dist. No. 08428 333

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

56 days

3. (a) FULL NAME

Horseman

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Delaware County DelawareCity or town Delaware b.c.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced ✓

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) June 20, 1946 6. (c) If alive, give age _____ years8. AGE: Years _____ Months 56 Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Salisbury Md.
(Town, county and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Howard Horseman13. Birthplace Wenona Md.14. Maiden name Fouza Wehster15. Birthplace Wenona Md.16. Informant Mrs Howard Horseman

Address _____

17. Burial Date thereof Aug 16th 1946
(Burial, cremation, or removal) (month) (day) (year)Cemetery or crematory St Paul's M.E.Location Wenona Md.18. Funeral director L. G. WehsterAddress Deal Island Md.19. 8/16 19 46 Barziet Registrar

(Date recd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 19 46 at 11 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21, 1946 to Aug 15, 1946and that I last saw him alive on Aug 15, 1946

Immediate cause of death

Cerebral hemorrhage

DURATION

7 hrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE BarzietAddress Salisbury M. D. or other _____Date signed Aug 16

RECEIVED

AUG 19 1945

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 08429 333

1. PLACE OF DEATH
 County Salisbury
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
P.B. Hospital.
 How long in hospital or institution? (Sallye)

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State MD County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2601. Jefferson St.
 (If rural give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME
Sallye E. Hurley

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife Theophilus Hurley
 7. Birth date of deceased (mo., day, yr.) Nov. 16 - 1860 6. (c) If alive, give age Dr. J. J. Hurley years

8. AGE: Years 85 Months 9 Days 8 If less than one day
 hrs. min.

9. Birthplace Bergeton Del.
 (Town, county, and state)

10. Usual occupation Home work

11. Industry or business John Wiley

12. Name John Wiley

13. Birthplace Surrey Co. Del.

14. Maiden name Elinor

15. Birthplace Bergeton Del.

16. Informant Mrs. Herman Giese

Address 2601. Jefferson St. Balt. Md.

Dr. J. J. Hurley Date thereof Aug. 27-46

(Burial, cremation, or removal, which?)

Cemetery or crematory Proton Cem.

Location Salisbury Md.

18. Funeral director Hallway & Co. Walter R. Hall

Address Salisbury Md.

19. 8/27 19 46 Harriet L. Johnson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24 19 46 at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 22 19 46 to Aug. 24 19 46

and that I last saw her alive on Aug. 24 19 46

Immediate cause of death Cerebral Thrombosis

DURATION

Due to.....

Due to.....

Other conditions Myocardial Infarction

(Include pregnancy within 8 months of death)

Major findings of operations Myocardial Infarction

Date of op. 8/24/46

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Mode of injury..... Injured at work?

23. SIGNATURE J. J. Hurley M. D. or other

Address Salisbury Md. Date signed 8/26/46

RECEIVED
AUG 29 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution? 14 days - 17 hrs 45 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester
 City or town Summerville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Hallie Jester
 4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Single

3. (b) Social Security Number

090-03-4077

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1946 at 12 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 13 1946 to Aug 28 1946
 and that I last saw him alive on Aug 28 1946

Immediate cause of death Carcinoma of liver
 DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of liver Date of op. 8-15-46

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

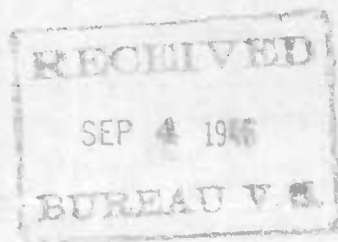
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE L.R. Gramse M.D. M. D. or other _____Address Salisbury, Md. Date signed 5-28-46

6.(b) Name of husband or wife _____
 7. Birth date of deceased (mo., day, year) Dec 9, 1901
 8. AGE: Years 44 Months 8 Days 19 If less than one day _____ hrs. _____ min.
 9. Birthplace Chincoteague Va
 (Town, county and state)
 10. Usual occupation Telephone operator
 11. Industry or business _____
 12. Name John Jester
 13. Birthplace Chincoteague Va
 14. Maiden name Audasia Birch
 15. Birthplace Chincoteague Va
 16. Informant Ludiana Drilling
 Address Chincoteague Va
 17. Burial Burial Date thereof Sept 1 1946
 (Burial, cremation, or other. Which?) (Day) (year)
 Cemetery or crematory Mechanics Cemetery
 Location Chincoteague Va
 18. Funeral director Walter H. Black
 Address Chincoteague Va
 19. 8/31/46 Registrar Harriet E. Johnson
 (Date rec'd by registrar)



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 339

1. PLACE OF DEATH:

County *Salisbury*City or town *Salisbury Md.*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.* County *Salisbury*City or town *Salisbury*
(If outside city or town limits, write RURAL and give nearest town)Street No. *P.O. #1.*
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Annie Eliza Jones

3. (b) Social Security Number

4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Widow*8. (b) Name of husband or wife *George Henry Jones*7. Birth date of deceased (mo., day, yr.) *Jan. 22-1860*

6. (c) If alive, give age _____ years

8. AGE: Years *86* Months *6* Days *26* It less than one day _____ hrs. _____ min.9. Birthplace *Allen Md.*
(Town, county, and state)10. Usual occupation *House work*

11. Industry or business

12. Name *Alfred Murrell*13. Birthplace *Mt. Vernon Md.*14. Maiden name *Pierce*15. Birthplace *Allen Md.*16. Informant *Mrs. Clarence White*Address *P.O. #1, Salisbury Md.*17. Burial Date thereof *Aug. 21-46*
(Burial, cremation, or removal? Which?) (month) (day) (year)Cemetery or crematory *Fruitland Mem.*Location *Fruitland Md.*18. Funeral director *Helwig & C. Walter R. Helwig*Address *Salisbury Md.*19. *8/19/46*
(Date recd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 18-46* 19 *46* at *8:30* PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Medical Examiner* 19 _____ to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death *CORONARY OCCLUSION* DURATION *Immediate*Due to *CORONARY SCLEROSIS*

Due to _____

Other conditions *HYPERTENSIVE CARDIO-vascular DISEASE*

(Include pregnancy within 3 months of death)

Major findings of operations *none*

Date of op. _____

Autopsy results *none*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE *E. Rivers Hanson M.D.*Address *Salisbury, Md.*Date signed *8-19-46*

Acting Dep. Med. Exam.

MARGIN RESERVED FOR BINDING

VS A15 9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 22 1946

BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of year MARYLAND STATE DEPARTMENT OF HEALTH
of birth of deceased is shown on 2411 N. Charles St., Baltimore 957

FILM No. I O 6 AUG 26 1946

CERTIFICATE OF DEATH

Reg. Diat. No. 08432 939

1. PLACE OF DEATH:

County... Wilomica
City or town... Salisbury md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... md County... Wilomica
City or town... Salisbury md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 402 Garden St
(If rural, give LOCATION) no
2.(a) If veteran, name war no

3. (a) FULL NAME

Hester Mae Jones

3. (b) Social Security Number

no

4. Sex female 5. Color or race a. a. 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife no

7. Birth date of deceased (mo., day, yr.) Dec 26 1928 1918 6. (c) If alive, give age no years

8. AGE: Years 17 Months 7 Days 14 It less than one day no hrs. no min.

9. Birthplace... Salisbury md
(Town, county, and state)

10. Usual occupation... School Girl

11. Industry or business same as above

12. Name... Otha Jones

13. Birthplace Chandee md

14. Maiden name Eda Washell

15. Birthplace Danvers Quarter

16. Informant Mrs Eda Jones

Address Salisbury md

17. Burial (Burial, cremation, or removal. Which) Burial Date thereof Aug 12 - 1946

Cemetery or crematory Hawton

Location Salisbury md

18. Funeral director James H. Stewart

Address Salisbury md

19. 8/12, 1946 Registrar Harris E. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11, 1946 at 12:00 Noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 8, 1946 to Aug 11, 1946 and that I last saw him alive on Aug 11, 1946

Immediate cause of death Congestive Heart Failure

Due to Rheumatic Heart Disease

Due to no

Other conditions no

(Include pregnancy within 3 months of death)

Major findings of operations no

Date of op. no

Antopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of no

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) no

Means of injury no Injured at work? no

23. SIGNATURE John H. Jones M. D. or other

Address 438 Camden Ave Date signed Aug 13, 1946

RECEIVED

AUG 15 1946

BUREAU V F

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08433

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? About one hour
 Hospital, institution, or street address where death occurred:
Penninsula General Hospital
 How long in hospital or institution? about one hour

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Wicomico
 City or town Allen Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. no
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Lasella Jones

3. (b) Social Security Number

no

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female a.a. Single

B. (b) Name of husband or wife no7. Birth date of deceased (mo., day, yr.) Aug 2 1945 6. (c) If alive, give age years

8. AGE: Years 1 Months 8 Days 12 If less than one day
 hrs. min.

9. Birthplace Allen Md
(Town, county, and state)10. Usual occupation no11. Industry or business no12. Name Thomas Jones13. Birthplace Florida14. Maiden name Lovely Mae Quinell15. Birthplace Florida16. Informant Lovely Mae QuinellAddress Allen Md17. Burial Date thereof Aug 16 - 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory NaustonLocation Salisbury Md18. Funeral director James H. StewartAddress Salisbury Md19. 8/19 19 46 Registrar Harriet E. Johnson

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 46 3:12 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Aug 14 (2:30am) 46 Aug 14 3:12am
 and that I last saw him alive on Aug 14 1946

Immediate cause of death Breast - ProlapsedDURATION UnknownDue to Not been sick several days but unable to get additional infusionDue to gts additional infusion

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

Signature Thos R MannAddress Salisbury Md M. D. or otherDate signed 8/14/46

RECEIVED
AUG 22 1945
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

8434

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Seven days (7)
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town Ocean City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Elgar
Saw, Mrs. Eddie M. Maris

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Saw, Mrs. Christine

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1885 6. (c) If alive, give age 60 years

8. AGE: Years 61 Months 5 Days 15 If less than one day _____ hrs. _____ min.

9. Birthplace STERLING Illinois
 (Town, county, and state)

10. Usual occupation Sign Painter

11. Industry or business

12. Name Thomas J. Laws

13. Birthplace

Penn.

14. Maiden name

Martha S. Chudy

15. Birthplace

Penn.

16. Informant Mrs. E. M. Law

Address Ocean City Md

17. Burial Date thereof 8/15/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Episcopalism Am

Location Berlin Md.

18. Funeral director Anna A. Burban

Address Berlin Md.

19. 8/16-46 Registrar Harriet E. Johnson
 (Date recd by registrar) (month) (day) (year)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1946 at 8¹⁵ P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 6 1946 to August 13 1946
 and that I last saw him alive on August 13 1946

Immediate cause of death

Acute Coronary Artery

occlusion with infarction 8 days

Due to Coronary Artery Symptoms 6 years

arteriosclerosis

Due to _____ Symptoms 6 years

Other conditions Essential

Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE David J. Gilmore M.D.

Address 301 N. Division Street M. D. or other _____
Salisbury, Md. Date signed Aug 13, 1946

AUG 20 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

08435

CERTIFICATE OF DEATH

Reg. Dist. No. 393

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since 5/24/46
 Hospital, institution, or street address where death occurred:
Eastern Shore Tb. Sanatorium
 How long in hospital or institution? Since 5/24/46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town Berlin, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 128 S. Main Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war ☒

3. (a) FULL NAME

Lewis, Nelson

3. (b) Social Security Number

219-14-4432

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Divorced
 6.(b) Name of husband or wife Hattie Thornton Lewis
 7. Birth date of deceased (mo., day, yr.) Feb. 1, 1905 6.(c) If alive, give age 41 years
 8. AGE: Years 41 Months 6 Days 5 If less than one day _____ hrs. _____ min.

9. Birthplace Chincoteague, Va.
 (Town, county, and state)

10. Usual occupation Waterman

11. Industry or business

FATHER 12. Name George Washington Lewis
 13. Birthplace Virginia
 MOTHER 14. Maiden name Elisa Hall
 15. Birthplace Virginia

16. Informant self
 Address _____

17. Burial Date thereof Aug 18-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mechanics Cemetery
 Location Chincoteague Va

18. Funeral director Walter M. Belack
 Address Chincoteague Va

19. 8/18/46 19 46 Barrie G. Johnson
 (Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 19 46 at 3:20a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/24/46 19 46 to 8/16/46 19 46
 and that I last saw him alive on 8/16/46 19 46

Immediate cause of death _____ DURATION _____

Pulmonary Tuberculosis

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Paul Chen W.D.
 M. D. or other _____

Address Ston Hill, Va Date signed 8/18/46

RECEIVED

AUG 22 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (79)

CERTIFICATE OF DEATH

08436

330

Reg. Dist. No.

1. PLACE OF DEATH:

County..... WicomicoCity or town..... Mardela
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... 52 years

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... WicomicoCity or town..... Mardela
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

4. Sex..... F5. Color or race..... white6. (a) Single, married, widowed, or divorced..... widowB.(b) Name of husband or wife..... Levin Lowe7. Birth date of deceased (mo., day, yr.)..... Jan 11 1866

B.(c) If alive, give age..... years

8. AGE: Years..... 80 Months..... 7 Days..... 13

If less than one day..... hrs. min.

9. Birthplace..... Mardela, Wic, Md
(Town, county, and state)10. Usual occupation..... Housework

11. Industry or business.....

12. Name..... Samuel R. Windsor13. Birthplace..... Md.14. Maiden name..... Elizabeth A. Bailey15. Birthplace..... Md.16. Informant..... Mrs. Ella L. MitchellAddress..... Salisbury, Md.17. (Burial, cremation, or removal, which?)..... BurialDate thereof..... 8 27-1946
(month) (day) (year)Cemetery or crematory..... Mardela MdLocation..... " "18. Funeral director..... Gravener BrosAddress..... Sharpton Md.19. 8/27/46..... W.H. Robertson
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Aug 24 1946 at 8 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 1946 to Aug 24 1946
and that I last saw her..... alive on Aug 25 1946Immediate cause of death..... Pericarditis

DURATION

1 year

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... H. Kuhlman M.D.Address..... Sharpton Md Date signed..... 8/27/46

RECEIVED
SEP 5 1946
BUREAU

Dr. Rademaker

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08437

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WorcesterCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Penninsula General Hospital

How long in hospital or institution?

8 hrs - 41 mins.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester CoCity or town Whaleysville Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. 1st. world war
(If rural, give LOCATION)2.(a) If veteran, name war 1st. world war ✓

3. (a) FULL NAME

Lynch, John Franklin

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Florence Lynch7. Birth date of deceased (mo., day, yr.) Dec. 22, 1896 6. (c) If alive, give age _____ years8. AGE: Years 49 Months 7 Days 14 If less than one day _____ hrs. _____ min.9. Birthplace Worcester Co. Md.
(Town, county, and estate)10. Usual occupation Farmer, carpenter

11. Industry or business

12. Name George W. Lynch13. Birthplace Md.14. Maiden name Olivia Ennis15. Birthplace Worcester Co. Md.16. Informant Florence LynchAddress Whaleysville, Md.17. Burial 8/8/46
(Burial, cremation, or removal. Which?) Date thereof _____ (month) (day) (year)Cemetery or crematory Bethel CemeteryLocation near Whaleysville, Md.18. Funeral director Henry S. WalgonAddress Pocomoke City, Md.19. 8/8/46 L. Harrison Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 19 46 at 12 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____
and that I last saw _____ alive on _____ 19 _____Immediate cause of death Coronary occlusion

DURATION

10 minsDue to Fractured femur left
multiple lacerations of body4 hrsDue to _____
Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. _____

noneAutopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 8/5/46Where did injury occur? Pittsboro Worcester Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HighwayMeans of injury Head - on collision Injured at work? noDr. Rademaker M.D.23. SIGNATURE Deputy Med. Examiner M. D. or other _____Address Salisbury, Md Date signed 8/6/46

MARGIN RESERVED FOR BINDING

VS A15 9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 10 1946
BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157-02

CERTIFICATE OF DEATH

Reg. Dist. No. 08438 333

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 39 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 308 Naylor St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Mach. Gerald Keith Jr.

3. (b) Social Security Number

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug. 3-1946 6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
1 0 39 hrs. min.

9. Birthplace Pen. Ben. Hopt. Salisbury Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Gerald Keith Mach
13. Birthplace Antigo, Wisc.

14. Maiden name Louise Phyllis
15. Birthplace Salisbury Maryland

16. Informant M. Guard of V.K. Mach
Address 308 Naylor St. Salisbury Md

17. Burial (Burial, cremation, or removal) Aug. 76-1946
Date thereof (month) (day) (year)

Cemetery or crematory Pharon Cem.
Location Salisbury Maryland

18. Funeral director W. G. Miller P. Wilson
Address Salisbury Maryland

19. 8/6/46 (Date rec'd by registrar) 19. 46 Registrar Harriet E. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5 19. 46 at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 3 19. 46 to Aug 5 19. 46
and that I last saw him alive on Aug 4 19. 46

Immediate cause of death Respiratory failure
Due to Hydrocephalous
Spina bifida

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert R. Starn
M. D. or other Salisbury
Address Salisbury Date signed 8-5-46

MARGIN RESERVED FOR BINDING

VS A15 9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 8 1946

BUREAU V 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

18. Informant.....

Address.....

17.

(Burial, cremation, or removal Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral Director.....

Address.....

19.

(Date rec'd by Registrar)

19.

(Date rec'd by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

19. 46 9 30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw deceased alive on..... 19.

Immediate cause of death.....

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

Date signed.....

MARGIN RESERVED FOR BINDING

VS A15

9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08439

RECEIVED
AUG 26 1946
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-2

CERTIFICATE OF DEATH

08440

Reg. Dist. No. 833

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:

415 Davis St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County WicomicoCity or town _____
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Daniel W. Melson

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

malewhitesingle

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) March 4, 1861

6. (c) If alive, give age _____ years

8. AGE: Years 85 Months 5 Days 7 If less than one day _____ hrs. _____ min.9. Birthplace Wicomico Co. Md
(Town, county, and state)10. Usual occupation None

11. Industry or business _____

12. Name Daniel F. Melson13. Birthplace Wicomico Co. Md14. Maiden name Sarah White15. Birthplace Wicomico Co. Md16. Informant Mr. Bliss MelsonAddress Salisbury, Md17. Burial Date thereof Aug. 14, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rockawalkin Church CemeteryLocation Rockawalkin, Md18. Funeral director The Hill & Johnson Co.Address Salisbury, Md19. 8/14, 1946 Harriet E. Johnson
(Date read by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11, 1946 19 46 11 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 46 to 19 46and that I last saw him alive on 19 46Immediate cause of death Usemed

DURATION

3 daysDue to chronic hepatitis.2

Due to _____

Other conditions old Fracture, right hip.2

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

M. D. or other

Address Salisbury, Md Date signed 8-13-46

RECEIVED

AUG 20 1945

BUREAU V. 8

17
-18
3661

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

08441

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH:

County... Wicomico
 City or town... Bivalve
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 13 yrs.
 Hospital, institution, or street address where death occurred:
Bivalve, Md.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Wicomico
 City or town... Bivalve
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

William Buddy Mutschler

3. (b) Social Security Number

4. Sex... m 5. Color or race... white 6.(a) Single, married, widowed, or divorced... widower
 6.(b) Name of husband or wife... Mary E. Mutschler
 7. Birth date of deceased (mo., day, yr.)... Dec. 14, 1897
 8. AGE: Years... 68 Months... 8 Days... 7 It less than one day... hrs. min.
 6.(c) If alive, give age... years

9. Birthplace... Philadelphia, Pa.
 (Town, county, and state)
 10. Usual occupation... Brass molder
 11. Industry or business

12. Name... Joseph B. Mutschler
 13. Birthplace... Bamberg, Germany
 14. Maiden name... Mary E. Buddy
 15. Birthplace... Ireland

16. Informant... Gladys Mutschler
 Address... Bivalve, Md.

17. Burial... Burial Date thereof... 8/24/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Greenwich Cemetery
 Location... Greenwich, Conn.

18. Funeral director... C. E. Messing
 Address... Bivalve, Md.

19. Aug 22 1946 R. Woodford Waller
 (Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... August 21st 1946 at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from... 19... to... 19...
 and that I last saw him alive on... August 19 19... 46

Immediate cause of death... Insanition
 Due to... Generalized Carcinomatosis
 Due to... Carcinoma of Stomach
 Other conditions...
 (Include pregnancy within 3 months of death)

Major findings of operations...
 Date of op.

Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of ...
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of Injury Injured at work?

23. SIGNATURE... Robert J. Gore
 Address... Wantage, Md. Date signed... 8-22-46
 M. D. or other

RECEIVED

SEP 5 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08442

Reg. Dist. No. 393

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 days 16 hrs. 39 mins.
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution? 9 days 16 hrs. 39 mins.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Virginia County Stafford
 City or town Bell Haven
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(c) If veteran, name war _____

3. (a) FULL NAME

Nicholson, Mr. Elijah

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Corra E. Nicholson
 7. Birth date of deceased (mo., day, yr.) July 8, 1873 6. (c) If alive, give age 71 years
 8. AGE: Years 73 Months 1 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Shenando Co., Md.
(Town, county, and state)10. Usual occupation Retired farmer

11. Industry or business _____

12. Name John H. Nicholson13. Birthplace Maryland14. Maiden name Nettie Simmons15. Birthplace Maryland16. Informant Mrs. Cora E. NicholsonAddress Bell Haven, Va.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 8/16/46

(month) (day) (year)

Cemetery or crematory BethesdaLocation Bethesda, Md.18. Funeral director The Hall & Johnson Co.Address Salisbury, Md.19. 8/15 19. 46 Registrar John H. Johnson

(Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1946 at 5:39 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 4 1946 to Aug 14 1946and that I last saw him alive on Aug 14 1946Immediate cause of death HypertrophiedChronic MyocarditisDue to Chronic Myocarditis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John H. Johnson M. D. or other _____Address Salisbury Date signed 8/17/46

RECEIVED

AUG 20 1946

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(73-2)

108443

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County..... WicomicoCity or town..... Eden Rural 2
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... 60 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MD County..... WicomicoCity or town..... Eden Rural 2
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex..... female 5. Color or race..... white 6. (a) Single, married, ~~separated~~, or divorced..... Widowed8. (b) Name of husband or wife..... David A. Pryor

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... Dec. 16, 18578. AGE: Years..... 88 Months..... 7 Days..... 22 If less than one day..... hrs. min.9. Birthplace..... Wicomico Co. Md
(Town, county, and state)10. Usual occupation..... At Home

11. Industry or business.....

12. Name..... John Owens13. Birthplace..... Wicomico, Co. Md14. Maiden name..... Dennis15. Birthplace..... Worcester Co. Md.16. Informant..... Mrs. James PalmerAddress..... Fruitland, Md17. Burial..... Date thereof..... Aug. 9, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Wicomico Memorial ParkLocation..... Salisbury, Md18. Funeral director..... The Hill & Johnson Co.Address..... Salisbury, Md19. 8/16/46 19 46 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Aug. 7, 1946 19 46 10 30 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-20- 19 46 to 8-7- 19 46 and that I last saw her alive on 7-30- 19 46Immediate cause of death..... Acute Right Vent FailureDue to..... Smoking

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Lu L. Lundy md M. D. or other
Address..... Salisbury, Md Date signed..... 8-9-46

MARGIN RESERVED FOR BINDING

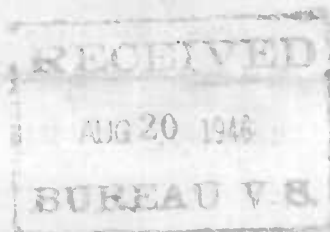
VS A15 9-45-150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mar 4,

85

23
46
68



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

08444

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 DayHospital, institution, or street address where death occurred:
P.S. Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Pocomoke City Rural #2
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2.(a) If veteran, name war 70 ✓

3. (a) FULL NAME

Baby Purnell

3. (b) Social Security Number

None

4. Sex

male

5. Color or race

balan

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

August 12 - 1946

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

It less than one day

hrs.

min.

122hrs.min.2hrs.

000

RECEIVED
AUG 20 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93D

CERTIFICATE OF DEATH

08446

Reg. Dist. No. 959

1. PLACE OF DEATH:

County McCombs
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 36 years
 Hospital, institution, or street address where death occurred:
R.D. #2
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
 State McCombs County Salisbury
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.D. #2
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Lewis Phillips Reitz

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 1st 1946 2408

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 1st 1944 to July 3rd 1944and that I last saw him alive on July 3rd 1944Immediate cause of death He was in my hands

DURATION

8. AGE: Years 90 Months 6 Days 12 If less than one day9. Birthplace Baltimore Maryland10. Usual occupation Retired on Farm11. Industry or business Formerly Black Blower12. Name George Friedrich Reitz13. Birthplace Germany14. Maiden name Mary Ann Early15. Birthplace New Jersey16. Informant Mrs. Martha E. ReitzAddress R.D. #2, Salisbury Maryland17. Burial Aug. 4-46

(Burial, cremation, or reburial, which) Date thereof (month) (day) (year)

Cemetery or crematory Charity Church Cem.Location R.D. #2, Salisbury Md.18. Funeral director Hollman & Co. R. HollmanAddress Salisbury Maryland19. 8/3/46

(Date rec'd by registrar) Registrar

22. SIGNATURE William E. ErickAddress Thurmont Md. M. D. otherDate signed Aug. 2-46

RECEIVED

AUG 8 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

CERTIFICATE OF DEATH

08445

Reg. Dist. No. 333

1. PLACE OF DEATH:

County... Wicomico
 City or town... Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Days - 10 hrs.
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution? 3 Days - 10 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... MD County... Worcester
 City or town... Berlin
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war... ☒

3. (a) FULL NAME

Roach, Mr. Andrew William

3. (b) Social Security Number

4. Sex... Male 5. Color or race... White 6. (a) Single, married, widowed, or divorced... Married
 6. (b) Name of husband or wife... Sally Roach
 6. (c) If alive, give age... 49 years
 7. Birth date of deceased (mo., day, yr.)... April 2, 1884
 8. AGE: Years... 62 Months... 3 Days... 29 If less than one day... hrs. _____ min. _____

9. Birthplace... Penn.
(Town, county, and state)10. Usual occupation... merchant

11. Industry or business

12. Name... William Roach13. Birthplace... Pa.14. Maiden name... Annie Messmer15. Birthplace... Pottstown, Pa.16. Informant... Mrs. Andrew RoachAddress... Berlin MD17. Burial... Buried Date thereof... 8/3/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... EvergreenLocation... Berlin MD18. Funeral director... Anna D. BurbageAddress... Berlin MD19. 8/3, 1946 Registrar... Barrie E. Johnson

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... August 1, 1946 at 2:25 PM

21. CERTIFY that death occurred on the date above stated; that I attended deceased from July 28, 1946 to August 1, 1946
 and that I last saw him alive on August 1, 1946

Immediate cause of death... Acute Coronary Artery Occlusion with myocardial infarction
 Due to... arteriosclerosis of Coronary arteries
 Due to... _____

DURATION

6 days
5 symptoms
6 mos.

Other conditions... _____

(Include pregnancy within 3 months of death)

Major findings of operations... _____

Autopsy results... _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... _____ Date of... _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury... _____ Injured at work? _____

Signature... David J. Gilmore M.D.Address... Salisbury, Md. M. D. or other... _____Date signed... Aug 1, 1946

RECEIVED

AUG 8 1946

BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (158)

CERTIFICATE OF DEATH

08447 238
Reg. Dist. No.

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days - 16 hours
Hospital, institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution? 2 days - 16 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Rural Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION) _____
2.(a) If veteran, name war _____ ✓

3. (a) FULL NAME

Schoolfield, Rosalie

3. (b) Social Security Number

4. Sex Female 5. Color or race colored 6. (a) Single, married, widowed, or divorced single
6. (b) Name of husband or wife _____
7. Birth date of deceased (mo., day, yr.) July 5 - 1946 6. (c) If alive, give age _____ years
8. AGE: Years _____ Months 28 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Pocomoke Wicomico Md.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

FATHER 12. Name Charles Schoolfield
13. Birthplace Md.

MOTHER 14. Maiden name Carrie Murrell
15. Birthplace Md.

16. Informant Charles Schoolfield
Address Rural Pocomoke Md.

17. Burial, cremation, or removal Buried Date thereof Aug 3 - 1946
(month) (day) (year)

Cemetery or crematory Unionville Cemetery
Location Rural Pocomoke Md.

18. Funeral director Sherry S. Watson
Address Pocomoke Md.

19. 8/16 19 46 Barrie L. Johnson
(Date rec'd by registrar) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3 19 46, at 8:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31 19 46, to Aug 2 19 46, and that I last saw her alive on Aug 2 19 46.

Immediate cause of death malnutrition DURATION 1 hr.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations none Date of op. _____

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Lo Rademahr M. D. or other _____
Address Salisbury, Md. Date signed 8/3/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 8 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Diat. No. 64 330

1. PLACE OF DEATH:

County Wicomico
 City or town Mardela Springs - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 31 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
 City or town Mardela Springs - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Harvey C. Thomas

3. (b) Social Security Number

215 - 26 - 4166

4. Sex male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Betha Thomas
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) March 24, 1912
 8. AGE: Years 34 Months 5 Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Luxey County, Delaware
 (Town, county, and state)
 10. Usual occupation Day Laborer
 11. Industry or business Farm
 12. Name Frederick Thomas
 13. Birthplace Wicomico County, Maryland
 14. Maiden name Edna Hopkins
 15. Birthplace Wicomico County, Maryland
 16. Informant Mrs. Edna Thomas
 Address Mardela Springs, Maryland, RFD.
 17. Burial Date thereof August 29, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mardela Methodist Cemetery
 Location Mardela Springs Maryland, RFD
 18. Funeral director J. J. Frampton and Son
 Address Federalburg, Maryland
 19. August 29, 1946 S. S. Frampton
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1946 at 5 A. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____
 and that I last saw _____ alive on _____

Immediate cause of death Coronary Occlusion
 DURATION Sudden
Death

Due to _____
 Due to _____
 Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations No
 Date of op. _____

Autopsy results No
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Dr. Rudolph W. W. W.
Physician M. D. or other _____
 Address Federalburg, Md Date signed 8/28/46

RECEIVED
SEP 10 1946
BUREAU V S

Reg. Diat. No. 333

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH: County <u>Wicomico</u> City or town <u>Salisbury</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>12 years</u> Hospital, institution, or street address where death occurred: <u>Peninsula General Hospital</u> How long in hospital or institution? <u>5 days</u> | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Ma</u> County <u>Wicomico</u> City or town <u>Fruitland</u> (If outside city or town limits, write RURAL and give nearest town) Street No. _____ (If rural, give LOCATION) 2.(a) If veteran, name war _____ | | | |
| 3. (a) FULL NAME <u>Jasper Lee White</u> | | | | 3. (b) Social Security Number _____ | | | |
| 4. Sex <u>male</u> 5. Color or race <u>white</u> 6. (a) Single, married, widowed, or divorced <u>married</u> 6. (b) Name of husband or wife <u>Mattie M. White</u> 6. (c) If alive, give age <u>56</u> years 7. Birth date of deceased (mo., day, yr.) <u>Nov. 24, 1882</u> 8. AGE: Years <u>63</u> Months <u>8</u> Days <u>23</u> If less than one day _____ hrs. _____ min. 9. Birthplace <u>Wicomico Co., Md</u> (Town, county, and state) 10. Usual occupation <u>Farmer</u> 11. Industry or business _____ | | | | MEDICAL CERTIFICATION 20. DATE OF DEATH <u>Aug. 16, 1946</u> 19____ 21____ 715P. 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>May 10, 1946</u> to <u>Aug. 16, 1946</u> and that I last saw him alive on <u>Aug. 16, 1946</u> Immediate cause of death <u>Arteriosclerosis</u> Due to _____ Other conditions _____ (Include pregnancy within 3 months of death) Major findings of operations _____ Autopsy results _____ PHYSICIAN: Please underline the cause in which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____ | | | |
| 12. Name <u>Thomas H. White</u> 13. Birthplace <u>Wicomico Co., Md</u> 14. Maiden name <u>Mary E. Harris</u> 15. Birthplace <u>Wicomico Co., Md</u> 16. Informant <u>Mrs. Jasper L. White</u> Address <u>Fruitland, Md</u> 17. Burial (Burial, cremation, or removal, Which?) <u>Burial</u> Date thereof <u>Aug. 18, 1946</u> (month) (day) (year) Cemetery or crematory <u>Siloam Cemetery</u> Location <u>Siloam, Md</u> 18. Funeral director <u>The Hill & Johnson Co.</u> Address <u>Salisbury, Md</u> 19. Registrar <u>Harris E. Johnson</u> Date signed <u>8/26/46</u> (Date rec'd by registrar) | | | | 23. SIGNATURE <u>John H. Haman</u> M.D. Address <u>238 Cambridge</u> Date signed <u>Aug 16, 1946</u> | | | |

RECEIVED
AUG 28 1946
BUREAU V B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

08450

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State..... County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife.....

7. Birth date of
deceased (mo., day, yr.)

8. (c) If alive, give age..... Years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

10. Usual occupation.....

11. Industry or business.....

MOTHER

FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. (Burial, cremation, or removal, which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date read by registrar)

19.....

19.....

19.....

19.....

19.....

19.....

19.....

19.....

19.....

19.....

19.....

19.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 19..... at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1, 1946, to August 17, 1946.

and that I last saw him alive on August 17, 1946.

Immediate cause of death.....

DURATION

2 yrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Date signed.....

MARGIN RESERVED FOR BINDING

VS 415 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C. 20530

Handwritten signature

ANTHONY J. LEO

RECEIVED
AUG 23 1946
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131-2

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
 City or town SALISBURY, MD.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 days 7 hrs. 40 min.
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution? 10 days 7 hrs. 40 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
MD. Salisbury
 State MD. County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 100 N. Division
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Williamson, Mr. John Thomas

3. (b) Social Security Number

4. Sex male 5. Color or race white (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Marie Maude Witherspoon

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1906 6. (c) If alive, give age 35 years

8. AGE: Years 40 Months 5 Days 19 If less than one day _____ hrs. _____ min.

9. Birthplace Bridgetown Delaware
 (Town, county, and state)

10. Usual occupation Operator of Restaurant

11. Industry or business Restaurant

12. Name John Mitchell Williamson

13. Birthplace Virginia

14. Maiden name Annie E. Jones

15. Birthplace Bridgetown Delaware

16. Informant Mrs. Marie M. Williamson

Address 100 N. Division St. Salisbury MD

17. Burial Date thereof Aug 15 - 1946

(Burial, cremation, or removal, which?) (month, day, year)

Cemetery or crematory W.C. Mem. Park

Location Salisbury Maryland

18. Funeral director Hillman & Co. Wm. P. Hillman

Address Salisbury Maryland

19. 8/15/46 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1946, at 7:40 p.m.

that death occurred on the date above stated; that I attended deceased from 8-2 1946 to 8-13 1946

and that I last saw him alive on 8-13 1946

Immediate cause of death Terminia

DURATION

Due to Cardio-vascular renal disease

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

21. SIGNATURE Philip A. Jones M. D. or other

Address Salisbury MD Date signed 8-14-46

AUG 20 1946

BUREAU V.S.

PLEASE, WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17003

CERTIFICATE OF DEATH

Reg. Dist. No. 933

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? About 2 hours
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution? About 2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset
 City or town Princess Anne
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War II ✓

3. (a) FULL NAME

Stanley Wales Wilson

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) February 22, 1927

6. (c) If alive, give age _____ years

8. AGE: Years Months Days If less than one day
19 5 19 _____ hrs. _____ min.

9. Birthplace Princess Anne, Maryland
(Town, county, and state)10. Usual occupation Mechanic11. Industry or business Garage12. Name Oscar Edward Wilson13. Birthplace Oriole, Maryland14. Maiden name Mrs. Grace Hosea15. Birthplace Salisbury, Maryland16. Informant Shirley M. WilsonAddress Princess Anne, Maryland17. Burial Date thereof Aug. 11, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Andrew's CemeteryLocation Princess Anne, Maryland18. Funeral director Charles M. DashiellAddress Princess Anne, Md.

19. 8/11/46 19 46 Barrie O. Johnson
 (Date rec'd by registrar) (year) (month) (day) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 19 46 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ to _____

and that I last saw him _____ alive on _____

Immediate cause of death Crushed skull DURATIONbroken neck

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VERIFICATION: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date 8/10/46Where did injury occur? Near Princess Anne, Somerset, Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public placeMeans of injury Auto accident Injured at work? no23. SIGNATURE Henry M. Lambford, M.D. M. D. or otherAddress Princess Anne, Md. Date signed 8/11/46

RECEIVED

AUG 16 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 152

CERTIFICATE OF DEATH

Reg. Dist. No. 322

1. PLACE OF DEATH:

County... Wicomico
 City or town... Salisbury, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since 7/8/46
 Hospital, institution, or street address where death occurred:
Eastern Shore Tuberculosis Sanatorium
 How long in hospital or institution? Since 7/8/46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Talbot
 City or town... R. F. D. Easton, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R. F. D.
 (If rural, give LOCATION) ✓
 2.(a) If veteran, name war... No

3. (a) FULL NAME

Winterbottom, James Harrison

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1878 6.(c) If alive, give age..... years

8. AGE: Years 67 Months 10 Days 16 It less than one day
hrs.min.

9. Birthplace Royal Oak, Maryland
 (Town, county, and state)

10. Usual occupation... Carpenter

11. Industry or business

12. Name... James Thomas Winterbottom13. Birthplace Talbot County, Maryland14. Maiden name... Hattie Couk15. Birthplace Baltimore, Maryland16. Informant self

Address

17. Burial Date thereof Sept 2, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Spring HillLocation... Easton Md.18. Funeral director... Maurice E. Newman SonAddress Easton Md.

19. 9/21/46 19. 46
 (Date rec'd by registrar) Registrar M. E. Newman

MEDICAL CERTIFICATION

20. DATE OF DEATH... August 30 19. 46 at 9:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July 8 19. 46 to Aug. 30 19. 46

and that I last saw him alive on Aug. 30 19. 46

Immediate cause of death...
For Advanced Pulmonary Tuberculosis DURATION 14 yrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statitically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Paul Chen M. D. or otherAddress... Snow Hill, Maryland Date signed 8/31/46

RECEIVED

SEP 26 1946

BUREAU V.E.